BEFORE THE
DIVISION OF MEDICAL QUALITY
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against:	)	
KHOSROW I. DANESHVAR, M.D.	)	File No. 06-1999-105096
Physician's and Surgeon's Certificate No. A 48714	)	
Respondent.	)	

DECISION

The attached Stipulation for Practice Restriction and Public Letter of Reprimand; and Order is hereby adopted as the Decision and Order of the Division of Medical Quality of the Medical Board of California, Department of Consumer Affairs, State of California.

This Decision shall become effective at 5:00 p.m. on August 6, 2003.

IT IS SO ORDERED July 7, 2003.

MEDICAL BOARD OF CALIFORNIA

By: _____
Lorie G. Rice, Chair
Panel A
Division of Medical Quality

BILL LOCKYER, Attorney General
of the State of California
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Attorneys for Complainant

BEFORE THE
DIVISION OF MEDICAL QUALITY
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: KHOSROW I. DANESHVAR, M.D. 242 South Robertson Boulevard, #2 Beverly Hills, California 90211 Physician and Surgeon's Certificate No. A 48714 Respondent.	Case No. 06-1999-105096 OAH No. L-2001060168 **STIPULATION FOR PRACTICE RESTRICTION AND PUBLIC LETTER OF REPRIMAND; AND ORDER**

IT IS HEREBY STIPULATED AND AGREED by and between the parties to the above-entitled proceedings that the following matters are true:

PARTIES

1. Ron Joseph (Complainant) is the Executive Director of the Medical Board of California. He brought this action solely in his official capacity and is represented in this matter by Bill Lockyer, Attorney General of the State of California, by Paul C. Ament, Deputy Attorney General.

2. Respondent Khosrow I. Daneshvar, M.D. (Respondent) is represented in this proceeding by attorney Peter R. Osinoff, Esq., whose address is 3699 Wilshire Boulevard, 10th Floor, Los Angeles, California 90010.

3. On or about October 9, 1990, the Medical Board of California issued

Physician and Surgeon's Certificate No. A 48714 to Khosrow I. Daneshvar, M.D. (Respondent). The Certificate was in full force and effect at all times relevant to the charges brought in Accusation No. 06-1999-105096 and will expire on October 31, 2004 unless renewed.

JURISDICTION

4. Accusation No. 06-1999-105096 was filed before the Division of Medical Quality (Division) for the Medical Board of California, Department of Consumer Affairs, and is currently pending against Respondent. The Accusation and all other statutorily required documents were properly served on Respondent on May 4, 2001. Respondent timely filed his Notice of Defense contesting the Accusation. A copy of Accusation No. 06-1999-105096 is attached as exhibit A and incorporated herein by reference.

ADVISEMENT AND WAIVERS

5. Respondent has carefully read, fully discussed with counsel, and understands the charges and allegations in Accusation No. 06-1999-105096. Respondent has also carefully read, fully discussed with counsel, and understands the effects of this Stipulation for Practice Restriction and Public Letter of Reprimand.

6. Respondent is fully aware of his legal rights in this matter, including the right to a hearing on the charges and allegations in the Accusation; the right to be represented by counsel at his own expense; the right to confront and cross-examine the witnesses against him; the right to present evidence and to testify on his own behalf; the right to the issuance of subpoenas to compel the attendance of witnesses and the production of documents; the right to reconsideration and court review of an adverse decision; and all other rights accorded by the California Administrative Procedure Act and other applicable laws.

7. Respondent voluntarily, knowingly, and intelligently waives and gives up each and every right set forth above.

8. Respondent understands and agrees that the charges and allegations in Accusation No. 06-1999-105096, if proven at a hearing, constitute cause for imposing discipline upon his Physician and Surgeon's Certificate.

9. For the purpose of resolving the Accusation without the expense and

uncertainty of further proceedings, Respondent agrees that, at a hearing, Complainant could establish a factual basis for one or more of the charges in the Accusation, and that Respondent hereby gives up his right to contest those charges.

10. Respondent agrees that his Physician and Surgeon's Certificate is subject to discipline and he agrees to be bound by the Division's imposition of discipline as set forth in the Disciplinary Order below.

CONTINGENCY

11. This stipulation shall be subject to approval by the Division of Medical Quality. Respondent understands and agrees that counsel for Complainant and the staff of the Medical Board of California may communicate directly with the Division regarding this stipulation and settlement, without notice to or participation by Respondent or his counsel. By signing the stipulation, Respondent understands and agrees that he may not withdraw his agreement or seek to rescind the stipulation prior to the time the Division considers and acts upon it. If the Division fails to adopt this stipulation as its Decision and Order, the Stipulation for Practice Restriction and Public Letter of Reprimand and Disciplinary Order shall be of no force or effect, except for this paragraph, it shall be inadmissible in any legal action between the parties, and the Division shall not be disqualified from further action by having considered this matter.

12. The parties understand and agree that facsimile copies of this Stipulation for Practice Restriction and Public Letter of Reprimand and Disciplinary Order, including facsimile signatures thereto, shall have the same force and effect as the originals.

13. In consideration of the foregoing admissions and stipulations, the parties agree that the Division may, without further notice or formal proceeding, issue and enter the following Disciplinary Order:

DISCIPLINARY ORDER

a. PRACTICE RESTRICTION: Respondent is prohibited from placing any central lines. (Hereinafter, this restriction will sometimes be referred to as the "practice restriction.") The practice restriction is to remain in effect for as long as Respondent's Physician

and Surgeon's certificate remains in force.

b. PRACTICE MONITORING: In order to verify Respondent's compliance with the practice restriction set forth in paragraphs 13.a., Respondent, within 30 days of the effective date of this decision, shall submit to the Division or its designee for its prior approval a plan of practice in which Respondent's practice shall be monitored by another physician in Respondent's field of practice. Respondent shall have the monitor submit to the Division or its designee a report on a date six months after the effective date of this decision (hereinafter referred to as "the first report of the monitor"), and at six-month intervals thereafter until the date on which Respondent's license is currently set to expire (October 31, 2004). Each of these reports shall state whether or not Respondent has fully complied with the practice restriction against the placement of central lines.

c. SUSPENSION FOR FAILURE TO COMPLY WITH PRACTICE RESTRICTION: If the first report of the monitor indicates that Respondent has not fully complied with the practice restriction, Respondent shall be suspended from the practice of medicine pending further order of the Division.

d. NON-RENEWAL OF LICENSE FOR FAILURE TO COMPLY WITH PRACTICE RESTRICTION: Respondent agrees that, in the event that any of the reports of the practice monitor issued on or before the date on which Respondent's license is currently set to expire (October 31, 2004) indicates that Respondent has failed fully to comply with the practice restriction set forth in paragraph 13.a. above, Respondent's Physician and Surgeon's certificate will not be renewed. If Respondent's Physician and Surgeon's certificate is renewed on or after October 31, 2004, Respondent agrees that any failure on his part thereafter to fully comply with the practice restriction set forth in paragraph 13.a. will constitute good and sufficient cause for the non-renewal of his Physician and Surgeon's Certificate as such Certificate comes up for renewal.

e. COST RECOVERY: Respondent is hereby ordered to reimburse the division the amount of three thousand dollars ($3,000.00) within six months of the effective date of this decision for its investigative and prosecution costs. The filing of bankruptcy by

Respondent shall not relieve Respondent of his responsibility to reimburse the Division for its investigative and prosecution costs.

f. PUBLIC LETTER OF REPRIMAND: If the first report of the monitor indicates that Respondent has to that point fully complied with the practice restriction set forth in paragraph 13.a., and if Respondent fully and in a timely manner reimburses the Division for its investigative and prosecution costs pursuant to paragraph 13.d. above, Complainant shall issue to Respondent a Public Letter of Reprimand, in accordance with Business and Professions Code section 2233, which shall constituted a final resolution of this matter. A draft copy of the Public Letter of Reprimand is attached hereto as Exhibit "B." The language used in the draft letter shall be the language used in the actual Public letter of Reprimand. Respondent shall agree to accept the Public Letter of Reprimand and shall further agree to waive any right to challenge or appeal its issuance.

ACCEPTANCE

I have carefully read the above Stipulation for Practice Restriction and Public Letter of Reprimand and Disciplinary Order and have fully discussed it with my attorney, Peter R. Osinoff. I understand the stipulation and the effect it will have on my Physician and Surgeon's Certificate. I enter into this Stipulation for Practice Restriction and Public Letter of Reprimand voluntarily, knowingly, and intelligently, and agree to be bound by the Decision and Order of the Division of Medical Quality, Medical Board of California.

DATED: 03/10/03.

K. Daneshvar

KHOSROW I. DANESHVAR, M.D.
Respondent

I have read and fully discussed with Respondent Khosrow I. Daneshvar, M.D. the terms and conditions and other matters contained in the above Stipulation for Practice Restriction and Public Letter of Reprimand, and Disciplinary Order. I approve its form and content.

DATED: 4/2/03.

PETER R. OSINOFF
Attorney for Respondent

ENDORSEMENT

The foregoing Stipulation for Practice Restriction and Public Letter of Reprimand and Disciplinary Order is hereby respectfully submitted for consideration by the Division of Medical Quality, Medical Board of California of the Department of Consumer Affairs.

DATED: 6/23/03.

BILL LOCKYER, Attorney General
of the State of California

PAUL C. AMENT
Deputy Attorney General

Attorneys for Complainant

DOJ Docket Number: 03573160-LA2001AD0592

Exhibit A

Accusation No. 06-1999-105096

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BEFORE THE
DIVISION OF MEDICAL QUALITY
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: KHOSROW I. DANESHVAR, M.D. 242 S. Robertson Boulevard, #2 Beverly Hills, CA 90211 Physician and Surgeon Certificate No. A 48714 Respondent.	Case No. 06-1999-105096 **A C C U S A T I O N**

Complainant alleges:

PARTIES

1. Ron Joseph ("Complainant") brings this Accusation solely in his official capacity as the Executive Director of the Medical Board of California, Department of Consumer Affairs.

2. On or about October 9, 1990, the Medical Board of California issued Physician and Surgeon Certificate Number A 48714 to Khosrow I. Daneshvar, M.D. ("Respondent"). The Physician and Surgeon Certificate was in full force and effect at all times relevant to the charges brought herein and will expire on October 31, 2002, unless renewed.

JURISDICTION

3. This Accusation is brought before the Division of Medical Quality, Medical Board of California ("Division"), Department of Consumer Affairs, State of California ("Division"), under the authority of the following sections of the Business and Professions Code ("Code").

4. Section 2227 of the Code provides that a licensee who is found guilty under the Medical Practice Act may have his or her license revoked, suspended for a period not to exceed one year, placed on probation and required to pay the costs of probation monitoring, or such other action taken in relation to discipline as the Division deems proper.

5. Section 2234 of the Code states that the Division of Medical Quality shall take action against any licensee who is charged with unprofessional conduct. In addition to other provisions of this article, unprofessional conduct includes, but is not limited to, the following:

(a) Violating or attempting to violate, directly or indirectly, or assisting in or abetting the violation of, or conspiring to violate, any provision of this chapter.

(b) Gross negligence.

(c) Repeated negligent acts.

(d) Incompetence.

(e) The commission of any act involving dishonesty or corruption which is substantially related to the qualifications, functions, or duties of a physician and surgeon.

(f) Any action or conduct which would have warranted the denial of a certificate.

(g) The practice of medicine from this state into another state or country without meeting the legal requirements of that state or country for the practice of medicine. Section 2314 shall not apply to this subdivision. This subdivision shall become operative under the implementation of the proposed registration program described in Section 2052.5.

6. Section 125.3 of the Code provides, in pertinent part, that the Board may request the administrative law judge to direct a licentiate found to have committed a violation or

violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case.

7. Section 14124.12 of the Welfare and Institutions Code states:

(a) Upon receipt of written notice from the Medical Board of California, the Osteopathic Medical Board of California, or the Board of Dental Examiners of California, that a licensee's license has been placed on probation as a result of a disciplinary action, the department may not reimburse any Medi-Cal claim for the type of surgical service or invasive procedure that gave rise to the probation, including any dental surgery or invasive procedure, that was performed by the licensee on or after the effective date of probation and until the termination of all probationary terms and conditions or until the probationary period has ended, whichever occurs first. This section shall apply except in any case in which the relevant licensing board determines that compelling circumstances warrant the continued reimbursement during the probationary period of any Medi-Cal claim, including any claim for dental services, as so described. In such a case, the department shall continue to reimburse the licensee for all procedures, except for those invasive or surgical procedures for which the licensee was placed on probation.

FIRST CAUSE FOR DISCIPLINE

(Repeated Negligent Acts)

8. Respondent is subject to disciplinary action under section 2234, subdivision (c), of the Code in that respondent was repeatedly negligent in the care and treatment of patients. The circumstances are as follows:

PATIENT E.H.

A. On or about September 5, 1999, patient E.H., a 91 year old female in poor health with multiple medical problems, was admitted to Brotman Medical Center in Culver City, California, complaining of abdominal pain, nausea and diarrhea. The patient had previously been admitted and discharged with a diagnosis of urinary tract infection and systemic lupus erythematosis. Patient E.H. had been on Prednisone 10 mg

orally. X-rays were not diagnostic of her complaint. On or about September 6, 1999, respondent was consulted and asked to place a central line since the nurses were unable to access a peripheral vein. The patient was awake and talkative when respondent obtained consent for the central line. Respondent used an unternal jugular line placement technique on the left side of patient E.H.'s neck, which involved entering the jugular vein with a small bore needle followed by a large bore needle through which a guide wire was first advanced followed by a catheter. An X-ray revealed that the catheter, rather than going downward toward the superior vena cava or right heart, had curled backwards. Respondent left the left side in place and moved to the right side to attempt to insert the line but got an arterial stick. He removed the catheter and applied pressure for a good five minutes. The patient felt cold and clammy at this point. Respondent then attempted to place the line in the right groin but got another arterial stick. Respondent placed pressure on the site for five to ten minutes and also employed a 3 pound sand bag. The patient felt cold and clammy. The patient was given fluids through the left line that had been left inplace and was transferred to the intensive care unit (ICU), accompanied by respondent. The patient's blood pressure was 60-70 and she was shocky and received fresh frozen plasma, blood and fluids. Respondent requested assistance from cardiologist, a pulmonologist, a hematologist and the attending physician, suspecting a DIC. An EKG was done in the ICU. Patient E.H. arrested and resuscitative attempts were unsuccessful. Patient E.H.'s hematocrit/hemoglobin had fallen from an admission level of 36.50/12 gms on September 5, 1999 to Hgb 6.2 Hct 19.3 at 3:15 p.m. on September 6, 1999 at the time of the procedure, indicative of a major blood loss during the procedure.

B. On or about September 6, 1999, respondent was negligent in the care and treatment of patient E.H. when he failed to properly place a catheter for medication and fluid administration despite three attempts, which resulted in an extreme blood loss and a drop in the hematocrit from 36 to 19, leading to the patient's demise; and

when he failed to consider and perform on patient E.H. a controlled cutdown for venous access, thereby avoiding significant blood loss.

PATIENT S.M

C. On or about August 16, 1999, patient S.M., who had prostaic cancer, underwent a radical prostatectomy at Brotman Medical Center in Culver City, California. Post surgery in recovery room, patient S.M.'s potassium was found to be 8.6 and a nephrologist and cardiologist were consulted. Patient S.M. was diagnosed with acute renal failure and it was decided that renal dialysis would be the most effective treatment. A central line for dialysis was ordered by the nephrologist and respondent was called from home to place the line. Respondent obtained consent from patient S.M. The line was placed using the interior jugular method. Respondent placed the line on his first try in the patient's left neck, drew blood and inserted a Quinton catheter for dialysis. A chest x-ray was requested stat. There was a delay in taking the x-ray. During the delay, respondent responded to a code blue across the hall from patient S.M. Upon his return to patient S.M., the x-ray had been taken. Respondent reviewed the film himself and determined that there was no pneumothorax and that the catheter was satisfactory. Respondent failed to note the evidence of infiltrate or fluid in the left chest on the x-ray. A nurse entry in the chart for patient S.M. indicated that the central line did not aspirate. Subsequently, respondent indicated to the dialysis nurse that she could use the central line. Respondent then left the hospital. The patient was restless and was subsequently intubated. The x-ray taken to check the position of the tube reflected a great amount of fluid in the left chest. Thereafter the patient arrested. Resuscitative efforts failed. An autopsy revealed a perforation of the jugular vein with blood in the mediastinum and a significant amount of serial blood in the chest; it was concluded that a rather marked degree of hemorrhage had caused the patient's death.

D. On or about August 16, 1999, respondent was negligent in the care and treatment of patient S.M. when he indicated to the dialysis nurse that she could use

the central line, despite the existence of an x-ray showing fluid infiltrate in the chest and a nurse note indicating the line did not aspirate; and when, in the presence of fluid infiltrate in the left chest post placement of the central line, he failed to order either a decubitus x- ray or a specific test of the line to establish proper placement of the line.

SECOND CAUSE FOR DISCIPLINE

(Gross Neglience)

9. Respondent is subject to disciplinary action under section 2234, subdivision (b), of the Code in that respondent was grosly negligent in the care and treatment of patients. The circumstances are as follows:

A. The facts and circumstances alleged in paragraph 8 above are incorporated here as if fully set forth.

B. On or about August 16, 1999, respondent was grossly negligent in the care and treatment of patient S.M. when he indicated to the dialysis nurse that she could use the central line, despite the existence of an x-ray showing fluid infiltrate in the chest and a nurse note indicating the line did not aspirate.

C. On or about August 16, 1999, respondent was grossly negligent in the care and treatment of patient S.M. when, in the presence of fluid infiltrate in the left chest post placement of the central line, he failed to order either a decubitus x-ray or a specific dye test of the line to establish proper placement of the line.

THIRD CAUSE FOR DISCIPLINE

(Incompetence)

10. Respondent is subject to disciplinary action under section 2234, subdivision(d) in that respondent was incompetent in the care and treatment of patients. The circumstances are as follows:

A. The facts and circumstances alleged in paragraph 8 above are incorporated here as if fully set forth.

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Division of Medical Quality issue a decision:

1. Revoking or suspending Physician and Surgeon Certificate Number A 48714, issued to Khosrow I. Daneshvar, M.D.;

2. Revoking, suspending or denying approval of Khosrow I. Daneshvar, M.D.'s authority to supervise physician's assistants, pursuant to section 3527 of the Code;

3. Ordering Khosrow I. Daneshvar, M.D. to pay the Division of Medical Quality the reasonable costs of the investigation and enforcement of this case, and, if placed on probation, the costs of probation monitoring;

4. Taking such other and further action as deemed necessary and proper.

DATED: May 4, 2001

RON JOSEPH
Executive Director
Medical Board of California
Department of Consumer Affairs
State of California
Complainant

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/bb

Exhibit B
Draft of Public Letter of Reprimand

DRAFT OF PUBLIC LETTER OF REPRIMAND

On September 6, 1999, while practicing as a general surgeon, you were called to place a central venous line in a 91-year old female patient. She had been hospitalized in poor health with multiple medical problems, including sepsis and dehydration. Nurses had been unable to access a peripheral vein despite multiple attempts to do so. You were unsuccessful in three attempts to place a catheter for medication and fluid administration. After an x-ray revealed that the catheter in the left internal jugular vein had curled superiorly, you attempted to insert a line in the right side, but got an arterial stick. You then attempted to place a line in the right groin, but got another arterial stick. You should have attempted to reposition the initial catheter under fluoroscopic control, avoiding the need to re-puncture the patient. Failure to do so constitutes general unprofessional conduct within the meaning of California Business and Professions Code section 2234.

You have agreed to accept this Public Letter of Reprimand, and will not contest it. Accordingly, pursuant to Business and Professions Code section 2233, the Board hereby issues to you this Public Letter of Reprimand.